SPSO decision report

Case: **201707551, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained that the board unreasonably failed to make appropriate arrangements to deliver her baby by cesarean section (c-section) in line with her birth plan. Mrs C's waters broke two days before she was due to have her c- section at Wishaw General Hospital and she contacted the hospital for advice. Mrs C was told to return that evening and confirmed she still wished to have a c- section. After her arrival at hospital, Mrs C waited almost three hours before being clinically assessed. By the time she was examined she was 8cm dilated, and although staff started to prepare her for a c-section there was no theatre available and she progressed through labour, with her child eventually being delivered by forceps.

The board said that the department had been particularly busy, and that they had prioritised patients according to clinical need. Mrs C was unhappy with this response and brought her complaint to us.

We took independent advice from a consultant obstetrician (a doctor who specialises in pregnancy and childbirth). We found that there was no medical need to open a second theatre and that Mrs C and her baby has been appropriately monitored throughout the labour. However, Mrs C was on the 'red pathway' for her maternity care which highlights significant/obstetric risks and we found that there had been a delay in assessing her after her arrival at hospital. We considered that Mrs C should not have been left without adequate triage on her arrival at hospital. We upheld this aspect of Mrs C's complaint. However, we noted that the outcome may not have been different even if Mrs C had been examined sooner.

Mrs C also complained that the board's handling of her complaint was unreasonable. When Mrs C first raised her concerns with the board, she was offered a meeting with the consultant whose care she was under. At the end of the meeting the consultant suggested that Mrs C prepare a note setting out her account of what had happened. Mrs C understood she was making a formal complaint, but the consultant had actually asked for the account so that the Obstetric Risk Management Group could consider if a review of the case was required and identify any areas for learning. The misunderstanding came to light several months later, at which stage Mrs C was appropriately directed to the complaints process. Although we considered that the consultant had been acting in good faith, we were critical of the board's failure to identify Mrs C's concerns as a formal complaint. We upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the delay in assessing her. The apology should recognise the impact of her birth experience on her daily life.
- Apologise to Mrs C for failing to identify her concerns about her treatment as a formal complaint. The apologies should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leafletsand-guidance.

What we said should change to put things right in future:

- Relevant staff should take a pro-active approach to triage, ensuring clinical questions are asked and documented.

In relation to complaints handling, we recommended:

- Staff should be confident in recognising complaints. In cases where there is any lack of clarity over whether concerns should be treated as a formal complaint, steps should be taken to ascertain and clearly record the wishes of the patient.